Michigan Department of Community Health

MEDICAID BILLING AGENT AUTHORIZATION

COMPLETION INSTRUCTIONS:

- Type or Print Information.
- See page 2 for Certification Conditions.
- A separate, original form must be submitted for **EACH** provider.
- Copy both pages of this form for **YOUR** files.

NOTE:	"Billing Agent" is the business authorized by the Michigan Department of Community Health (MDCH) to submit Medicaid claims via electronic media.

I authorize (1. Billing Agent Name) _____ ,

(2. Billing Agent Identification Number) _____ to act as my agent for the purpose of preparing, processing and submitting claims on my behalf under the following Medicaid Provider Identification Number(s).

3. National Provider Identification Number | | | | | | | | | | |

4. Tax ID Number and/or Social Security Number | | | | | | | | | | |

PROVIDER CERTIFICATION:

- I understand that: 1) payment will be from federal and/or state funds, and 2) I may be prosecuted under applicable federal and/or state criminal and civil laws if my billing agent submits false claims or documents, or if I or my agent makes misrepresentations, conceals material facts, or conspires to engage in any of the above actions.
- I understand that it is my responsibility to notify my billing agent, upon receipt of the notice of my authorization from MDCH, before beginning to submit Medicaid claims.
- This authorization shall remain in effect until I notify the MDCH in writing to the contrary or MDCH negates it. As a condition of receiving payment from Medicaid and programs for which the MDCH is the fiscal intermediary for services billed on my behalf, I certify and agree to all of the provider certification conditions above and on page 2 of this document.

5. Provider's Name *(print)*	6. Provider's Phone Number ( )
7. Provider's Signature *(Facsimile signatures will NOT be accepted)*	8. Date

BILLING AGENT CERTIFICATION:

- I am a representative of the business authorized by MDCH to submit Medicaid claims via electronic media. My signature below signifies agreement to the billing agent certification conditions on page 2 of this document.

9. Billing Agent Representative's Name and Title (print)	10. Billing Agent's Phone Number ( )
11. Billing Agent Representative's Signature *(Facsimile signatures will NOT be accepted)*	12. Date

RETURN TO: PROVIDER ENROLLMENT
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
PO BOX 30238
LANSING MI 48909

PROVIDER CERTIFICATION CONDITIONS

I, the provider, agree to and certify as follows:

1. All the information I have furnished on this Billing Agent Authorization is true and complete.

2. All claims prepared, processed and submitted at my direction are true and valid claims for goods or services I properly provided to an eligible recipient under the applicable rules, regulations and polices of MDCH.

3. I am responsible for the accuracy and completeness of all claims transmitted to MDCH by my billing agent.

4. I am responsible for:
   a) reconciling my Medicaid accounts within 30 days after a remittance advice mailing, and
   b) notifying the MDCH of any payment errors and returning any overpayments due to these errors within the same 30 day period.

5. I acknowledge that my billing agent representative's signature constitutes my signature for all purposes related to Title XIX (Medicaid) reimbursement by the MDCH, including any administrative, civil and/or criminal action(s) relating to my participation in the Medicaid program. A lack of my billing agent representative's signature on claims made on my behalf shall not be used to avoid criminal and/or civil responsibility.

6. I will adhere to all rules, regulations and policies of the MDCH in billing services. These rules, regulations and policies are contained in my Medicaid Provider Agreement and the Medicaid Provider Manual (including manual updates, bulletins and/or other program notifications).

7. I may have disputed claims adjudicated in administrative hearings based on Act 280 of Public Acts of 1939, as amended, or in a court of law. If necessary, the state will pursue criminal and/or civil actions.

BILLING AGENT CERTIFICATION CONDITIONS

I, the billing agent, agree to and certify as follows:

1. All invoice information I submit to the MDCH on behalf of my client is a true and correct report of the information received from my client.

2. I understand that I may be prosecuted under applicable federal and/or state criminal and/or civil laws for submitting false claims, concealing material facts, misrepresentation, falsifying data systems input, other acts of misrepresentation, or conspiracy to engage therein.

3. I will maintain claims data for seven (7) years from the date of the service and be able to reproduce claims for resubmission or audit upon request from the MDCH.

4. Before billing for any medical services, I will review and fully comply with MDCH published billing policies and statutes.

5. I will allow, upon request and at a reasonable time and place, authorized federal and/or state government agents to inspect, copy, and/or take any records I maintain on the services provided and billed on behalf of my client.

Authority:	Title XIX of the Social Security Act	The Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.
Completion:	Is Voluntary, but is required for authorization of billing agent submission of claims.	